Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMB NVN635HOS			MBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C 07/02/2009		
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STATE, ZIP CODE ICAL PARKWAY				
CARSON	TAHOE REGIONAL	MEDICAL CENTE	CARSON C					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	(X5) COMPLETE DATE		
S 000	Initial Comments			S 000				
	This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 6/10/09 and finalized on 7/2/09, in accordance with Nevada Administrative Code, Chapter 449, Hospitals.				ari			
	Complaint #NV00021724 was substantiated with deficiencies cited. See Tag Z 146.							
	The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.							
S 146 SS=G	NAC 449.332 Discharge Planning			S 146				
	4. An evaluation of the needs of a patient relating to discharge planning must include, without limitation, consideration of: (a) The needs of the patient for postoperative services and the availability of those services; (b) The capacity of the patient for self-care; and (c) The possibility of returning the patient to a previous care setting or making another appropriate placement of the patient after discharge. This Regulation is not met as evidenced by: Based on record review and interview the facility failed to ensure a thorough evaluation of the discharge needs, the capacity for self-care, and the provision of necessary durable medical equipment upon discharge for 1 of 5 patients. (Patient #1)						1.00	
					SEP 0 4 2009 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA			
	Findings include:							
		nitted to the facility a						
deficiencie:	s are cited, an approved		e returned withi	n 10 days aft	er receipt of this statement of deficiencie	s.	(X6) DATE	

GRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 08/26/2009 FORM APPROVED

STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING C B. WING 07/02/2009 **NVN635HOS** STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1600 MEDICAL PARKWAY** CARSON TAHOE REGIONAL MEDICAL CENTE CARSON CITY, NV 89703 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID 1D COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S 146 Continued From page 1 S 146 Plan of correction NV 00021724 the facility on 3/15/09 with diagnoses of hepatic **Tag S146** encephalopathy, hepatitis with cirrhosis, history of Page 2 of 4 (a) frequent falls, history of recent fracture of proximal humeral diaphysis, anxiety disorder with claustrophobia, history of chronic pain syndrome, Record review completed by the and history of depression. The initial discharge Manager Integrated Care planning assessment was completed on 3/16/09. Management validates that The original discharge plan was for skilled original discharge plan did include nursing facility (SNF) placement. Patient #1 skilled nursing facility placement for refused SNF placement and alternate discharge the patient and that the patient planning began. refused this placement. Additionally, the patient received a psychiatric Patient #1's record was reviewed and revealed a evaluation on 3/26/2009. note that she "was admitted through the emergency room at (the facility) after being determined that she was capable of brought in with vague complaints of altered level making her own decisions. Not only of consciousness, left shoulder pain and did she refuse SNF placement, but it generalized weakness. The patient had recently is documented that she also refused traveled here (Nevada) from California and was to use her SSI monies to pay for staying at a local motel for approximately two alternative care, such as a group days prior to coming in. Apparently she had a home. couple of falls on her left shoulder in California and was diagnosed with a left proximal humeral The Patient also completed an diaphysis fracture." Advanced Directive on 3/23/2009, in which she established her sister as Patient #1's orders included orders for physical therapy (PT) and occupational therapy (OT) on her spokesperson. her day of admission. Review of the PT and OT notes revealed the patient frequently declined to participate. The PT long term goal was to ambulate 50 feet with a front wheeled walker. PT discharged the patient from the service on 3/31/09 "due to continued refusal and lack of participation." The PT discharge note was written in the physician progress notes, and PT documented that nursing was aware of the discharge from PT services. She was discharged from OT on 4/7/09 for decreased motivation and participation. An order for PT/OT to evaluate and treat was written again on 4/7/07. Both PT

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Bureau of Health Care Quality & Compliance

STM711

Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING _ NVN635HOS 07/02/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1600 MEDICAL PARKWAY** CARSON TAHOE REGIONAL MEDICAL CENTE CARSON CITY, NV 89703 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S 146 S 146 Continued From page 1 the facility on 3/15/09 with diagnoses of hepatic encephalopathy, hepatitis with cirrhosis, history of Plan of correction NV 00021724 frequent falls, history of recent fracture of Tag S146, continued proximal humeral diaphysis, anxiety disorder with Page 2 of 4 (b) claustrophobia, history of chronic pain syndrome, and history of depression. The initial discharge Record review completed by the planning assessment was completed on 3/16/09. Manager of The original discharge plan was for skilled Integrated Care Management validates that nursing facility (SNF) placement. Patient #1 patient demonstrated variability in refused SNF placement and alternate discharge planning began. her ability and/or willingness to ambulate. Patient #1's record was reviewed and revealed a At times, she was able to ambulate to note that she "was admitted through the the bathroom, and other times; she emergency room at (the facility) after being used a walker or a wheel chair. brought in with vague complaints of altered level of consciousness, left shoulder pain and The PT and OT staff did document, generalized weakness. The patient had recently in their therapy notes, this patients' traveled here (Nevada) from California and was staying at a local motel for approximately two abilities and progress. days prior to coming in. Apparently she had a couple of falls on her left shoulder in California Nursing discharge documentation on and was diagnosed with a left proximal humeral the "Discharge Assessment" did state diaphysis fracture." "ambulates with assist/assistive device". Patient #1's orders included orders for physical therapy (PT) and occupational therapy (OT) on her day of admission. Review of the PT and OT notes revealed the patient frequently declined to participate. The PT long term goal was to ambulate 50 feet with a front wheeled walker. PT discharged the patient from the service on 3/31/09 "due to continued refusal and lack of participation." The PT discharge note was written in the physician progress notes, and PT documented that nursing was aware of the discharge from PT services. She was discharged from OT on 4/7/09 for decreased motivation and participation. An order for PT/OT to evaluate and treat was written again on 4/7/07. Both PT

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FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING C B. WING NVN635HOS 07/02/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1600 MEDICAL PARKWAY CARSON TAHOE REGIONAL MEDICAL CENTE CARSON CITY, NV 89703 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S 146 Continued From page 1 S 146 the facility on 3/15/09 with diagnoses of hepatic Plan of correction NV 00021724 encephalopathy, hepatitis with cirrhosis, history of frequent falls, history of recent fracture of Tag S146, continued proximal humeral diaphysis, anxiety disorder with Page 2 of 4 (c) claustrophobia, history of chronic pain syndrome, and history of depression. The initial discharge During the week of July 13 to July planning assessment was completed on 3/16/09. 17, Manager of ICM conducted The original discharge plan was for skilled impromptu and informal meetings nursing facility (SNF) placement. Patient #1 with the ICM staff and coached them refused SNF placement and alternate discharge individually regarding this specific planning began. patient and other patients in general. Discussions included review of the Patient #1's record was reviewed and revealed a note that she "was admitted through the "Discharge Assessment" emergency room at (the facility) after being discharge instructions for brought in with vague complaints of altered level completeness and for specific patient of consciousness, left shoulder pain and needs that should be addressed and generalized weakness. The patient had recently documented. Also discussed was the traveled here (Nevada) from California and was Durable Medical Equipment and staying at a local motel for approximately two other services needed by patients, days prior to coming in. Apparently she had a and the documentation in the ICM couple of falls on her left shoulder in California assessment and the case managers and was diagnosed with a left proximal humeral diaphysis fracture." transfer information regarding these needs to the Multidisciplinary Action Patient #1's orders included orders for physical Plan (MAP). The expectation is that therapy (PT) and occupational therapy (OT) on documentation will her day of admission. Review of the PT and OT consistently and immediately. notes revealed the patient frequently declined to participate. The PT long term goal was to ambulate 50 feet with a front wheeled walker. PT discharged the patient from the service on 3/31/09 "due to continued refusal and lack of participation." The PT discharge note was written in the physician progress notes, and PT documented that nursing was aware of the discharge from PT services. She was discharged from OT on 4/7/09 for decreased motivation and

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participation. An order for PT/OT to evaluate and treat was written again on 4/7/07. Both PT

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FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING C B. WING NVN635HOS 07/02/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1600 MEDICAL PARKWAY CARSON TAHOE REGIONAL MEDICAL CENTE CARSON CITY, NV 89703 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S 146 S 146 Continued From page 2 Plan of correction NV 00021724 and OT documented the discharge from services Tag S146, continued again on 4/8/09. PT documented "patient Page 3 of 4 (b) participates poorly and intermittently" and that zero progress had been made as of 4/8/09. The Manager of ICM conducts Review of the physician progress note revealed Interdisciplinary the physicians continued to document that Patient Conferences. Currently, ICM staff, #1 was deconditioned and she was participating Hospitalists, Rehab. financial in PT and OT after 3/31/09. counselors and Infection control attend the weekly Interdisciplinary The nursing notes and flow sheets for Patient #1 Care Conferences to discuss patient were reviewed and revealed she used oxygen care plans and progress. from 2-3 liters intermittently. On 4/7/09, the nurse These documented Patient #1 required the assistance of meetings are documented on the two to ambulate. On 4/8/09 - 4/9/09, Patient #1 Interdisciplinary Care Conference ambulated with a walker and gait belt assistance. forms (Exhibit B). The ICM Record review failed to reveal Patient #1 was manager will include on the weekly independent in ambulation prior to her discharge. agenda, a review of all patients who are greater than 7 day length of stay, The discharge plan for Patient #1 was to be as well as, any patients who are not transported to a women's homeless shelter in progressing with the plan of care that California. Patient #1 was in agreement with the has been established by therapy plan. Patient #1's sister was notified of the services or the physicians. The ICM discharge plan. manager has also sent invitations to Interview with the discharging nurse revealed the Therapy services supervisor and Patient #1 was able to "stand and pivot" and to /or manager and Nurse managers walk a few steps on the day of her discharge, and/or Charge nurses to attend these 4/10/09. weekly meetings to discuss these types of issues as well as other Review of the record failed to reveal either a

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wheelchair or walker was provided for Patient #1

discharge. The social worker reported the patient

at her discharge. The social worker confirmed

neither was ordered for Patient #1 prior to her

continued to refuse SNF placement and was in agreement with the discharge plan. Review of the record revealed documentation of multiple conversations with the California case manager who advised Patient #1 needed to be referred by issues. (Exhibit C and D) Meetings

are ongoing and expanded attendance

the

meeting

will begin with

scheduled for 9/3/09.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		NVN635HOS		B. WING		C 07/02/2009		
NAME OF F	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, S	STATE, ZIP CODE			
CAUCON TAUDE DECIDAR MEDICAL CENTE I			DICAL PARKWAY CITY, NV 89703					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	TIVE ACTION SHOULD BE COMPLETE CED TO THE APPROPRIATE DATE		
S 146	and OT documented the discharge from services again on 4/8/09. PT documented "patient participates poorly and intermittently" and that zero progress had been made as of 4/8/09. Review of the physician progress note revealed the physicians continued to document that Patient #1 was deconditioned and she was participating in PT and OT after 3/31/09.			S 146	Plan of correction NV 00029 Tag S146, continued Page 3 of 4 (c)			
					Beginning 9/1/09 and continu at least 12 months, the Inte Care Management Manage conduct chart audits on disc patient charts and review ind	egrated r will harged		
	were reviewed and from 2-3 liters interdocumented Patier two to ambulate. Cambulated with a water review faile	and flow sheets for P revealed she used o mittently. On 4/7/09, at #1 required the asson 4/8/09 - 4/9/09, Paralker and gait belt as d to reveal Patient #1 pulation prior to her decrease.	the nurse sistance of atient #1 ssistance.		Case Managers documentation includes documentation on the Manager Assessments, referrals for DME and Home and appropriate documentation patient's plan of care. The Manager will review 10 discharts per adult unit per month	n. This c Case MAP, Health n of the c ICM scharge		
	transported to a wo California. Patient plan. Patient #1's s discharge plan.	for Patient #1 was to men's homeless she #1 was in agreement sister was notified of ischarging nurse rev	elter in t with the the		information will be utiliz individual feedback, as w departmental feedback that provided to the unit manager	ed for ell as, will be s at the anagers		
	Patient #1 was able to "stand and pivot" and to walk a few steps on the day of her discharge, 4/10/09.				identifying opportunities improvement of patient care.	for		
	wheelchair or walke at her discharge. The neither was ordered discharge. The soc continued to refuse agreement with the the record revealed conversations with	rd failed to reveal either was provided for P The social worker cond for Patient #1 prior cial worker reported to SNF placement and discharge plan. Rev I documentation of mathe California case not the top to the social worker.	Patient #1 Ifirmed to her the patient I was in view of oultiple nanager					

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neither was ordered for Patient #1 prior to her

continued to refuse SNF placement and was in

agreement with the discharge plan. Review of

the record revealed documentation of multiple

conversations with the California case manager who advised Patient #1 needed to be referred by

discharge. The social worker reported the patient

Charge Nurse meeting on 9/11/09 to

review use of the MAP. Discussion

will include clarification of the

process, clarify expectations and

answer any questions.

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conversations with the California case manager who advised Patient #1 needed to be referred by

Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING _ **NVN635HOS** 07/02/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1600 MEDICAL PARKWAY CARSON TAHOE REGIONAL MEDICAL CENTE CARSON CITY, NV 89703 SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S 146 Continued From page 3 S 146 her primary physician in California for them to place her in a California facility. On 4/10/09, Patient #1 was transported from the facility to a women's shelter in California by a transport van. Statements by the driver and attendant were reviewed and revealed Patient #1 did not want to get out of the van when they arrived at the shelter. The driver and attendant persuaded Patient #1 to go into the shelter, and helped her into a chair, and left her with her belongings at the shelter. On 4/10/09, Patient #1 was admitted to an acute care hospital in California with encephalopathy. The discharge summary from the facility documented Patient #1 was admitted with extreme weakness and inability to care for herself. On discharge, 5/4/09, it was documented Patient #1 was able to walk 200-300 feet unassisted. Severity 3 Scope 1

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